



State of Wisconsin
2009 - 2010 LEGISLATURE

LRB-1538/P1
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DOA:.....Willing, BB0426 - Health insurance reform initiatives

FOR 2009-11 BUDGET -- NOT READY FOR INTRODUCTION

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1 AN ACT ...; relating to: the budget. ✓

Analysis by the Legislative Reference Bureau
INSURANCE

Independent review

Under current law, every insurer that issues a group or individual health benefit plan must have an internal grievance procedure under which an insured may submit a written grievance and a grievance panel must investigate the grievance and, if appropriate, take corrective action. In addition, every insurer that issues a group or individual health benefit plan must have an independent review procedure for review, after the internal grievance procedure has been exhausted, of certain decisions that are adverse to an insured. The adverse decision must relate to the insurer's denial of treatment or payment for treatment that the insurer determined was experimental or to the insurer's denial, reduction, or termination of a health care service or payment for a health care service on the basis that the health care service did not meet the plan's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness. An independent review may be conducted only by an independent review organization that has been certified by the Commissioner of Insurance (commissioner).

The bill adds the rescission of a policy or certificate and a coverage denial determination based on a preexisting condition exclusion to the types of adverse decisions that are eligible for review under a group or individual health benefit plan's independent review procedure. In addition, the bill requires every insurer that

issues individual health benefit plans to report to the commissioner annually the number of individual health benefit plans issued by the insurer in the preceding year and the number of individual health benefit plans with respect to which the insurer initiated or completed a cancellation or rescission in the preceding year.

Preexisting condition exclusions

Under current law, an insurer may impose a preexisting condition exclusion for up to two years under an individual health insurance policy. Under a group health insurance policy, a preexisting condition exclusion generally may not exceed one year. Additionally, under a group health insurance policy, an insurer is limited to imposing a preexisting condition exclusion only with respect to conditions for which an insured received treatment, or for which treatment was recommended, within six months before the insured's coverage began. Under an individual health insurance policy, an insurer is not limited with respect to how long before an insured's coverage began a condition must have existed to be considered a preexisting condition for an exclusion, and current law does not specify that the insured must have received treatment, or that treatment must have been recommended, for the condition. Thus, an insurer is free to impose a preexisting condition exclusion under an individual health insurance policy for any condition that may have existed at any time during the insured's lifetime that the insurer believes the insured should have known existed or for which the insurer believes the insured should have sought treatment. This bill provides that under an individual health insurance policy, an insurer may impose a preexisting condition exclusion for up to one year for a condition for which an insured received treatment, or for which treatment was recommended, within one year before the insured's coverage began.

Under current law, for purposes of determining how long a preexisting condition exclusion may be imposed under a group health benefit plan, if a person who enrolls in the group health benefit plan had other coverage before that enrollment, the person must be given credit for the time during which he or she was previously covered when determining how long a preexisting condition exclusion may be imposed under the new coverage. Previous coverage may not be counted for the credit, however, if the person did not have coverage for a period of 63 or more days before the person's new coverage commenced. This bill increases that amount of time, so that a person may get credit for previous coverage if it ended up to 90 days, rather than 63 days, before the person enrolled in the group health benefit plan.

Modifications at renewal of individual health insurance

With some exceptions, an insurer must renew an individual health insurance policy at the option of the insured. At renewal, the insurer may modify the policy form on a uniform basis among all individuals with coverage under that policy form. The bill requires an insurer, at renewal of an individual health insurance policy and at the request of the insured, to issue comparable coverage to the insured that the insurer currently offers that has more limited benefits or a higher deductible or to provide a higher deductible under the insured's current coverage. If the insurer issues the alternative coverage, the insurer may not rate the coverage for any health status that did not apply when the insured applied for the original coverage. An insurer issuing individual policies must annually mail to each insured under an

individual policy issued by the insurer a notice that informs the insured of his or her right to elect alternative coverage and that describes the alternatives available to the insured and the procedure for electing the alternative coverage.

Uniform application for individual health insurance

The bill requires the commissioner to promulgate rules prescribing uniform questions and the format for individual health insurance policy applications, which may not be more than ten pages long. After the effective date of the rules, all insurers offering individual health insurance policies must use the prescribed questions and format on an application for such a policy.

Dependent coverage

Current law contains a number of provisions related to coverage of dependents under health insurance policies. For example, a health insurer must cover a newly born child of an insured from the moment of birth, but may discontinue coverage after 60 days if the insured does not notify the insurer of the birth and pay any additional premium within those 60 days. If a health insurer covers a child of an insured, the health insurer must also cover any child of the insured's child until the insured's child is 18 years old. If a health insurer covers dependents up to a certain age, the health insurer may not terminate coverage of a dependent child who reaches that age if, and while, the child is incapable of self-sustaining employment because of mental retardation or physical handicap and is dependent on the insured for support and maintenance. If a health insurer covers a person as a dependent because the person is a full-time student, the health insurer must continue to cover that person if he or she ceases to be a full-time student due to a medically necessary leave of absence until the happening of one of a number of specified events, such as the person's obtaining other health care coverage or reaching the age at which coverage ends under the terms of the policy for a dependent who is covered because he or she is a full-time student. Current law, however, does not require a health insurer to cover a dependent of an insured up to any particular age or because a dependent is a full-time student.

Under this bill, a health insurer must offer to cover any child of an insured if the child is unmarried, is under 27 years old, and is not eligible for coverage under a group health benefit plan that is provided by his or her employer and for which his or her premium contribution is no greater than the premium amount for his or her dependent coverage under his or her parent's health insurance plan. Additionally, if the child is a full-time student but previously had his or her education interrupted by service in the national guard or reserves, the health insurer must offer dependent coverage for that child for as long as he or she is a full-time student, regardless of age.

The insurer must provide the coverage if the insured requests it, and may require that the insured provide annual written documentation that the dependent child satisfies the criteria for coverage. The bill specifies that an insurer must determine the premium for coverage of a dependent who is over 18 years of age on the same basis as the premium is determined for a younger dependent. The coverage requirement applies to all types of individual and group health insurance policies

Under

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Insert A-1

dependent coverage for

even if not a student

Insert A-2

and plans, including those offered by the state, and to self-insured health plans of counties, cities, villages, towns, school districts, and the state.

The bill does not eliminate any of the other requirements that exist in current law related to coverage of dependents.

HEALTH AND HUMAN SERVICES

OTHER HEALTH AND HUMAN SERVICES

The Health Insurance Risk-Sharing Plan (HIRSP), which is administered by the HIRSP Authority, provides health insurance coverage for persons who are covered under Medicare because they are disabled, persons who have tested positive for human immunodeficiency virus (HIV), persons who have been refused coverage, or coverage at an affordable price, in the private health insurance market because of their mental or physical health condition, and persons who do not currently have health insurance coverage but who were covered under certain types of health insurance coverage (creditable coverage) for at least 18 months in the past. Persons who are eligible for coverage under HIRSP on the basis of being denied coverage by a private insurer must have been denied coverage by two or more insurers. This bill changes that criterion for eligibility to a denial of coverage by one or more insurers. The lifetime limit of benefits that HIRSP will provide to an individual who is covered under HIRSP is \$1,000,000. The bill retains \$1,000,000 as the minimum lifetime limit of benefits under HIRSP but allows the HIRSP Authority to increase that lifetime limit.

For further information see the *state and local* fiscal estimate, which will be printed as an appendix to this bill.

The people of the state of Wisconsin, represented in senate and assembly, do enact as follows:

1 **SECTION 1.** 40.51 (8) of the statutes is amended to read:

2 40.51 (8) Every health care coverage plan offered by the state under sub. (6)
3 shall comply with ss. 631.89, 631.90, 631.93 (2), 631.95, 632.72 (2), 632.746 (1) to (8)
4 and (10), 632.747, 632.748, 632.83, 632.835, 632.85, 632.853, 632.855, 632.87 (3) to
5 ~~(5)~~ (6), 632.885, 632.895 (5m) and (8) to (15), and 632.896.

6 **SECTION 2.** 40.51 (8m) of the statutes is amended to read:

7 40.51 (8m) Every health care coverage plan offered by the group insurance
8 board under sub. (7) shall comply with ss. 631.95, 632.746 (1) to (8) and (10), 632.747,
9 632.748, 632.83, 632.835, 632.85, 632.853, 632.855, 632.885, and 632.895 (11) to (15).

1 **SECTION 3.** 66.0137 (4) of the statutes is amended to read:

2 66.0137 (4) **SELF-INSURED HEALTH PLANS.** If a city, including a 1st class city, or
3 a village provides health care benefits under its home rule power, or if a town
4 provides health care benefits, to its officers and employees on a self-insured basis,
5 the self-insured plan shall comply with ss. 49.493 (3) (d), 631.89, 631.90, 631.93 (2),
6 632.746 (10) (a) 2. and (b) 2., 632.747 (3), 632.85, 632.853, 632.855, 632.87 (4), and
7 (5), and (6), 632.885, 632.895 (9) to (15), 632.896, and ~~767.25 (4m)~~ (d) 767.513 (4).

8 **SECTION 4.** 111.91 (2) (t) of the statutes is created to read:

9 111.91 (2) (t) The requirements related to dependent coverage under s. 632.885.

10 **SECTION 5.** 120.13 (2) (g) of the statutes is amended to read:

11 120.13 (2) (g) Every self-insured plan under par. (b) shall comply with ss.
12 49.493 (3) (d), 631.89, 631.90, 631.93 (2), 632.746 (10) (a) 2. and (b) 2., 632.747 (3),
13 632.85, 632.853, 632.855, 632.87 (4) and, (5), and (6), 632.885, 632.895 (9) to (15),
14 632.896, and ~~767.25 (4m)~~ (d) 767.513 (4).

15 **SECTION 6.** 149.12 (1) (a) of the statutes is amended to read:

16 149.12 (1) (a) A notice of rejection of coverage from ~~2~~ one or more insurers.

17 **SECTION 7.** 149.12 (2) (c) of the statutes is amended to read:

18 149.12 (2) (c) No person on whose behalf the plan has paid out \$1,000,000 the
19 lifetime limit under s. 149.14 (2) (a) or more is eligible for coverage under the plan.

20 **SECTION 8.** 149.14 (2) (a) of the statutes is amended to read:

21 149.14 (2) (a) The plan shall provide every eligible person who is not eligible
22 for Medicare with major medical expense coverage. Major medical expense coverage
23 offered under the plan under this section shall pay an eligible person's covered
24 expenses, subject to deductible, copayment, and coinsurance payments, up to a

1 lifetime limit per covered individual of \$1,000,000 per covered individual or a higher
2 amount, as determined by the authority.

3 **SECTION 9.** 185.981 (4t) of the statutes is amended to read:

4 185.981 (4t) A sickness care plan operated by a cooperative association is
5 subject to ss. 252.14, 631.17, 631.89, 631.95, 632.72 (2), 632.745 to 632.749, 632.85,
6 632.853, 632.855, 632.87 (2m), (3), (4), and (5), and (6), 632.885, 632.895 (10) to (15),
7 and 632.897 (10) and chs. 149 and 155.

8 **SECTION 10.** 185.983 (1) (intro.) of the statutes is amended to read:

9 185.983 (1) (intro.) Every such voluntary nonprofit sickness care plan shall be
10 exempt from chs. 600 to 646, with the exception of ss. 601.04, 601.13, 601.31, 601.41,
11 601.42, 601.43, 601.44, 601.45, 611.67, 619.04, 628.34 (10), 631.17, 631.89, 631.93,
12 631.95, 632.72 (2), 632.745 to 632.749, 632.775, 632.79, 632.795, 632.85, 632.853,
13 632.855, 632.87 (2m), (3), (4), and (5), and (6), 632.885, 632.895 (5) and (9) to (15),
14 632.896, and 632.897 (10) and chs. 609, 630, 635, 645, and 646, but the sponsoring
15 association shall:

16 **SECTION 11.** 601.41 (10) of the statutes is created to read:

17 601.41 (10) UNIFORM APPLICATION FOR INDIVIDUAL HEALTH INSURANCE POLICIES.

18 (a) The commissioner shall by rule prescribe uniform questions and the format for
19 applications, which may not exceed 10 pages in length, for individual major medical
20 health insurance policies.

21 (b) After the effective date of the rules promulgated under par. (a), an insurer
22 may use only the prescribed questions and format for individual major medical
23 health insurance policy applications. The commissioner shall publish a notice in the
24 Wisconsin Administrative Register that states the effective date of the rules
25 promulgated under par. (a).

✓
Insert 6-15

1 (c) For purposes of this subsection, an individual major medical health
2 insurance policy includes health coverage provided on an individual basis through
3 an association.

4 **SECTION 12.** 601.428 of the statutes is created to read:

5 **601.428 Cancellation and rescission reports.** Beginning in 2009, every
6 insurer that issues individual health insurance policies shall annually report to the
7 commissioner the total number of individual health insurance policies that the
8 insurer issued in the preceding year and the total number of individual health
9 insurance policies with respect to which the insurer initiated or completed a
10 cancellation or rescission in the preceding year.

11 **SECTION 13.** 609.74 of the statutes is created to read:

12 **609.74 Coverage of dependents.** Limited service health organizations,
13 preferred provider plans, and defined network plans are subject to s. 632.885.

14 **SECTION 14.** 632.746 (2) (e) of the statutes is amended to read:

15 **632.746 (2) (e)** Paragraphs (c) and (d) do not apply to an individual after the
16 end of the first continuous period during which the individual was not covered under
17 any creditable coverage for at least ~~63~~ ⁹⁰ days. For purposes of this paragraph, any
18 waiting period or affiliation period for coverage under a group health plan or group
19 health benefit plan shall not be taken into account in determining the period before
20 enrollment in the group health plan or group health benefit plan.

****NOTE: I assumed you wanted to change the above paragraph, in addition to s.
632.746 (3) (b). Let me know if you do not.

21 **SECTION 15.** 632.746 (3) (b) of the statutes is amended to read:

22 **632.746 (3) (b)** With respect to enrollment of an individual under a group health
23 plan or a group health benefit plan, a period of creditable coverage after which the

1 individual was not covered under any creditable coverage for a period of at least 63
2 90 days before enrollment in the group health plan or group health benefit plan may
3 not be counted. For purposes of this paragraph, any waiting period or affiliation
4 period for coverage under the group health plan or group health benefit plan shall
5 not be taken into account in determining the period before enrollment in the group
6 health plan or group health benefit plan.

7 **SECTION 16.** 632.7497 of the statutes is created to read:

8 **632.7497 Modifications at renewal.** (1) In this section, "individual major
9 medical or comprehensive health benefit plan" includes coverage under a group
10 health benefit plan that is underwritten on an individual basis and issued to
11 individuals or families.

12 (2) An insurer that issues an individual major medical or comprehensive
13 health benefit plan shall, at the time of a coverage renewal, at the request of an
14 insured, permit the insured to do either of the following:

15 (a) Change his or her coverage to a different but comparable individual major
16 medical or comprehensive health benefit plan currently offered by the insurer with
17 more limited benefits or with a higher deductible.

18 (b) Modify his or her existing coverage by electing an optional higher
19 deductible, if any, under the individual major medical or comprehensive health
20 benefit plan.

21 (3) (a) The insurer may not impose any new preexisting condition exclusion
22 under the new or modified coverage under sub. (2) that did not apply to the insured's
23 original coverage and shall allow the insured credit under the new or modified
24 coverage for the period of original coverage.

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1 (b) For the new or modified coverage, the insurer may not rate for health status
2 other than on the insured's health status at the time the insured applied for the
3 original coverage and as the insured disclosed on the original application.

4 (4) (a) Annually, the insurer shall mail to each insured under an individual
5 major medical or comprehensive health benefit plan issued by the insurer, a notice
6 that includes all of the following information:

7 1. That the insured has the right to elect alternative coverage as described in
8 sub. (2).

9 2. A description of the alternatives available to the insured.

10 3. The procedure for making the election.

11 (b) The insurer shall mail the notice under par. (a) not more than 3 months nor
12 less than 60 days before the renewal date of the insured's plan.

13 (5) (a) Nothing in this section requires an insurer to issue alternative coverage
14 under sub. (2) if the insured's coverage may be nonrenewed or discontinued under
15 s. 632.7495 (2), (3) (b), or (4).

16 (b) Notwithstanding s. 600.01 (1) (b) 3. and 4., this section applies to a group
17 health benefit plan described in s. 600.01 (1) (b) 3. or 4. if that group health benefit
18 plan is an individual major medical or comprehensive health benefit plan as defined
19 in sub. (1).

20 **SECTION 17.** 632.76 (2) (a) of the statutes is amended to read:

21 632.76 (2) (a) No claim for loss incurred or disability commencing after ~~2~~
22 12 months from the date of issue of the policy may be reduced or denied on the ground
23 that a disease or physical condition existed prior to the effective date of coverage,
24 unless the condition was excluded from coverage by name or specific description by

1 a provision effective on the date of loss. This paragraph does not apply to a group
2 health benefit plan, as defined in s. 632.745 (9), which is subject to s. 632.746.

3 **SECTION 18.** 632.76 (2) (ac) of the statutes is created to read:

4 632.76 (2) (ac) An individual disability insurance policy, as defined in s.
5 632.895 (1) (a), may not define a preexisting condition more restrictively than a
6 condition for which medical advice was given or treatment was recommended by or
7 received from a physician within 12 months before the effective date of coverage.

8 **SECTION 19.** 632.76 (2) (b) of the statutes is amended to read:

9 632.76 (2) (b) Notwithstanding par. (a), no claim for loss incurred or disability
10 commencing after 6 months from the date of issue of a medicare supplement policy,
11 medicare replacement policy or long-term care insurance policy may be reduced or
12 denied on the ground that a disease or physical condition existed prior to the effective
13 date of coverage. ~~A~~ Notwithstanding par. (ac), a medicare supplement policy,
14 medicare replacement policy, or long-term care insurance policy may not define a
15 preexisting condition more restrictively than a condition for which medical advice
16 was given or treatment was recommended by or received from a physician within 6
17 months before the effective date of coverage. Notwithstanding par. (a), if on the basis
18 of information contained in an application for insurance a medicare supplement
19 policy, medicare replacement policy, or long-term care insurance policy excludes
20 from coverage a condition by name or specific description, the exclusion must
21 terminate no later than 6 months after the date of issue of the medicare supplement
22 policy, medicare replacement policy, or long-term care insurance policy. The
23 commissioner may by rule exempt from this paragraph certain classes of medicare
24 supplement policies, medicare replacement policies, and long-term care insurance

1 policies, if the commissioner finds the exemption is not adverse to the interests of
2 policyholders and certificate holders.

3 **SECTION 20.** 632.835 (title) of the statutes is amended to read:

4 **632.835 (title) Independent review of ~~adverse and experimental~~**
5 **treatment coverage denial determinations.**

6 **SECTION 21.** 632.835 (1) (ag) of the statutes is created to read:

7 632.835 (1) (ag) "Coverage denial determination" means an adverse
8 determination, an experimental treatment determination, a preexisting condition
9 exclusion denial determination, or the rescission of a policy or certificate.

10 **SECTION 22.** 632.835 (1) (cm) of the statutes is created to read:

11 632.835 (1) (cm) "Preexisting condition exclusion denial determination" means
12 a determination by or on behalf of an insurer that issues a health benefit plan
13 denying or terminating treatment or payment for treatment on the basis of a
14 preexisting condition exclusion, as defined in s. 632.745 (23).

15 **SECTION 23.** 632.835 (2) (a) of the statutes is amended to read:

16 632.835 (2) (a) Every insurer that issues a health benefit plan shall establish
17 an independent review procedure whereby an insured under the health benefit plan,
18 or his or her authorized representative, may request and obtain an independent
19 review of ~~an adverse determination or an experimental treatment~~ a coverage denial
20 determination made with respect to the insured.

21 **SECTION 24.** 632.835 (2) (b) of the statutes is amended to read:

22 632.835 (2) (b) If ~~an adverse determination or an experimental treatment~~ a
23 coverage denial determination is made, the insurer involved in the determination
24 shall provide notice to the insured of the insured's right to obtain the independent
25 review required under this section, how to request the review, and the time within

1 which the review must be requested. The notice shall include a current listing of
2 independent review organizations certified under sub. (4). An independent review
3 under this section may be conducted only by an independent review organization
4 certified under sub. (4) and selected by the insured.

5 **SECTION 25.** 632.835 (2) (bg) 3. of the statutes is amended to read:

6 632.835 (2) (bg) 3. For any ~~adverse determination or experimental treatment~~
7 coverage denial determination for which an explanation of benefits is not provided
8 to the insured, the insurer provides a notice that the insured may have a right to an
9 independent review after the internal grievance process and that an insured may be
10 entitled to expedited, independent review with respect to an urgent matter. The
11 notice shall also include a reference to the section of the policy or certificate that
12 contains the description of the independent review procedure as required under
13 subd. 1. The notice shall provide a toll-free telephone number and website, if
14 appropriate, where consumers may obtain additional information regarding
15 internal grievance and independent review processes.

16 **SECTION 26.** 632.835 (2) (c) of the statutes is amended to read:

17 632.835 (2) (c) Except as provided in par. (d), an insured must exhaust the
18 internal grievance procedure under s. 632.83 before the insured may request an
19 independent review under this section. Except as provided in sub. (9) (a), an insured
20 who uses the internal grievance procedure must request an independent review as
21 provided in sub. (3) (a) within 4 months after the insured receives notice of the
22 disposition of his or her grievance under s. 632.83 (3) (d).

23 **SECTION 27.** 632.835 (2) (e) of the statutes is created to read:

1 632.835 (2) (e) Nothing in this section requires an insured to request an
2 independent review before commencing a civil action relating to a coverage denial
3 determination.

4 **SECTION 28.** 632.835 (3) (a) of the statutes is amended to read:

5 632.835 (3) (a) To request an independent review, an insured or his or her
6 authorized representative shall provide timely written notice of the request for
7 independent review, and of the independent review organization selected, to the
8 insurer that made or on whose behalf was made the ~~adverse or experimental~~
9 treatment coverage denial determination. The insurer shall immediately notify the
10 commissioner and the independent review organization selected by the insured of
11 the request for independent review. The insured or his or her authorized
12 representative must pay a \$25 fee to the independent review organization. If the
13 insured prevails on the review, in whole or in part, the entire amount paid by the
14 insured or his or her authorized representative shall be refunded by the insurer to
15 the insured or his or her authorized representative. For each independent review in
16 which it is involved, an insurer shall pay a fee to the independent review
17 organization.

18 **SECTION 29.** 632.835 (3) (e) of the statutes is amended to read:

19 632.835 (3) (e) In addition to the information under pars. (b) and (c), the
20 independent review organization may accept for consideration any typed or printed,
21 verifiable medical or scientific evidence that the independent review organization
22 determines is relevant, regardless of whether the evidence has been submitted for
23 consideration at any time previously. The insurer and the insured shall submit to
24 the other party to the independent review any information submitted to the
25 independent review organization under this paragraph and pars. (b) and (c). If, on

1 the basis of any additional information, the insurer reconsiders the insured's
2 grievance and determines that the treatment that was the subject of the grievance
3 should be covered, or that the policy or certificate that was rescinded should be
4 reinstated, the independent review is terminated.

5 **SECTION 30.** 632.835 (3) (f) of the statutes is renumbered 632.835 (3) (f) 1. and
6 amended to read:

7 632.835 (3) (f) 1. If the independent review is not terminated under par. (e), the
8 independent review organization shall, within 30 business days after the expiration
9 of all time limits that apply in the matter, make a decision on the basis of the
10 documents and information submitted under this subsection. The decision shall be
11 in writing, signed on behalf of the independent review organization and served by
12 personal delivery or by mailing a copy to the insured or his or her authorized
13 representative and to the insurer. ~~A~~ Except as provided in subd. 2., a decision of an
14 independent review organization is binding on the insured and the insurer.

15 **SECTION 31.** 632.835 (3) (f) 2. of the statutes is created to read:

16 632.835 (3) (f) 2. A decision of an independent review organization regarding
17 a preexisting condition exclusion denial determination or a rescission is not binding
18 on the insured.

19 **SECTION 32.** 632.835 (3m) (a) of the statutes is amended to read:

20 632.835 (3m) (a) A decision of an independent review organization regarding
21 an adverse determination or a preexisting condition exclusion denial determination
22 must be consistent with the terms of the health benefit plan under which the adverse
23 determination or preexisting condition exclusion denial determination was made.

24 **SECTION 33.** 632.835 (6m) (a) of the statutes is amended to read:

1 632.835 (6m) (a) ~~Be~~ Unless the review relates to a rescission, be a health care
2 provider who is expert in treating the medical condition that is the subject of the
3 review and who is knowledgeable about the treatment that is the subject of the
4 review through current, actual clinical experience.

****NOTE: Because rescissions do not necessarily relate to a specific medical condition, I have excluded reviews of rescissions from the above requirement. Is this amendment okay? Would you prefer to treat the above paragraph differently?

5 **SECTION 34.** 632.835 (7) (b) of the statutes is amended to read:

6 632.835 (7) (b) A health benefit plan that is the subject of an independent
7 review and the insurer that issued the health benefit plan shall not be liable to any
8 person for damages attributable to the insurer's or plan's actions taken in compliance
9 with any decision regarding an adverse determination or an experimental treatment
10 determination rendered by a certified independent review organization.

11 **SECTION 35.** 632.835 (8) of the statutes is renumbered 632.835 (8) (a) and
12 amended to read:

13 632.835 (8) (a) Adverse and experimental treatment determinations. The
14 commissioner shall make a determination that at least one independent review
15 organization has been certified under sub. (4) that is able to effectively provide the
16 independent reviews required under this section for adverse determinations and
17 experimental treatment determinations and shall publish a notice in the Wisconsin
18 Administrative Register that states a date that is 2 months after the commissioner
19 makes that determination. The date stated in the notice shall be the date on which
20 the independent review procedure under this section begins operating with respect
21 to adverse determinations and experimental treatment determinations.

22 **SECTION 36.** 632.835 (8) (b) of the statutes is created to read:

1 632.835 (8) (b) *Preexisting condition exclusion denials and rescissions.* The
2 commissioner shall make a determination that at least one independent review
3 organization has been certified under sub. (4) that is able to effectively provide the
4 independent reviews required under this section for preexisting condition exclusion
5 denial determinations and rescissions and shall publish a notice in the Wisconsin
6 Administrative Register that states a date that is 2 months after the commissioner
7 makes that determination. The date stated in the notice shall be the date on which
8 the independent review procedure under this section begins operating with respect
9 to preexisting condition exclusion denial determinations and rescissions.

10 **SECTION 37.** 632.835 (9) of the statutes is renumbered 632.835 (9) (a) and
11 amended to read:

12 632.835 (9) (a) *Adverse and experimental treatment determinations.* The
13 independent review required under this section with respect to an adverse
14 determination or an experimental treatment determination shall be available to an
15 insured who receives notice of the disposition of his or her grievance under s. 632.83
16 (3) (d) on or after December 1, 2000. Notwithstanding sub. (2) (c), an insured who
17 receives notice of the disposition of his or her grievance under s. 632.83 (3) (d) on or
18 after December 1, 2000, but before June 15, 2002, with respect to an adverse
19 determination or an experimental treatment determination must request an
20 independent review no later than 4 months after June 15, 2002.

21 **SECTION 38.** 632.835 (9) (b) of the statutes is created to read:

22 632.835 (9) (b) *Preexisting condition exclusion denials and rescissions.* The
23 independent review required under this section with respect to a preexisting
24 condition exclusion denial determination or a rescission shall be available to an
25 insured who receives notice of the disposition of his or her grievance under s. 632.83

1 (3) (d) on or after the date stated in the notice published in the Wisconsin
2 Administrative Register by the commissioner under sub. (8) (b).

3 **SECTION 39.** 632.885 of the statutes is created to read:

4 **632.885 Coverage of dependents.** (1) DEFINITIONS. In this section:

5 (a) "Disability insurance policy" has the meaning given in s. 632.895 (1) (a).

6 (b) "Insured" includes an enrollee.

7 (c) "Self-insured health plan" has the meaning given in s. 632.745 (24).

8 (2) REQUIREMENT TO OFFER DEPENDENT COVERAGE. (a) Subject to ss. 632.88 and
9 632.895 (5), every insurer that issues a disability insurance policy, and every
10 self-insured health plan, shall offer and, if so requested by an applicant or an
11 insured, provide coverage for a child of the applicant or insured as a dependent of the
12 applicant or insured if the child satisfies all of the following criteria:

13 1. The child is less than 27 years of age.

14 2. The child is not married.

15 3. The child is not eligible for coverage under a group health benefit plan, as
16 defined in s. 632.745 (9), that is offered by the child's employer and for which the
17 amount of the child's premium contribution is no greater than the premium amount
18 for his or her coverage as a dependent under this section.

19 (b) Notwithstanding par. (a) 1., if the child served on active duty in the national
20 guard or in a reserve component of the U.S. armed forces, the coverage requirement
21 under this section applies, subject to par. (a) 2. and 3., as long as the child is a
22 full-time student, regardless of the child's age.

****NOTE: The instruction was that the child's education was interrupted by service in the national guard or reserves. Do you want to require coverage of any full-time student who served in the national guard or reserves, or do you want to limit the requirement to a child who actually completed a certain amount of higher education before serving in the national guard or reserves? What if they received an undergraduate

degree before serving and have now gone back to school for another degree? Do you want to require that they were actually attending school when they were called to active duty? If so, must they have been a full-time student at the time and under the age of 27? Does it matter how long they waited before returning to school after their active duty terminated?

1 (3) PREMIUM DETERMINATION. An insurer or self-insured health plan shall
2 determine the premium for coverage of a dependent who is over 18 years of age on
3 the same basis as the premium is determined for coverage of a dependent who is 18
4 years of age or younger.

5 (4) DOCUMENTATION OF CRITERIA SATISFACTION. An insurer or self-insured health
6 plan may require that an applicant or insured seeking coverage of a dependent child
7 provide written documentation, initially and annually thereafter, that the
8 dependent child satisfies the criteria for coverage under this section.

9 SECTION 40. 632.895 (15) (a) of the statutes is amended to read:

10 632.895 (15) (a) Subject to pars. (b) and (c), every disability insurance policy,
11 and every self-insured health plan of the state or a county, city, town, village, or
12 school district, that provides coverage for a person as a dependent of the insured
13 because the person is a full-time student, including the coverage under s. 632.885
14 (2) (b), shall continue to provide dependent coverage for the person if, due to a
15 medically necessary leave of absence, he or she ceases to be a full-time student.

***NOTE: Is this amendment okay? See my drafter's note regarding how to treat
s. 632.895 (15) (c).

16 **SECTION 9126. Nonstatutory provisions; Insurance.**

17 (1) RULES FOR UNIFORM APPLICATION. The commissioner of insurance shall
18 submit in proposed form the rules required under section 601.41 (10) (a) of the
19 statutes, as created by this act, to the legislative council staff under section 227.15
20 (1) of the statutes no later than the first day of the 12th month beginning after the
21 effective date of this subsection.

Insert 19-15 ✓

SECTION 9326. Initial applicability; Insurance.

(1) MODIFICATIONS AT RENEWAL. The treatment of section 632.7497 of the statutes first applies to individual major medical or comprehensive health benefit plans that are renewed on the effective date of this subsection.

(2) PREEXISTING CONDITION EXCLUSIONS. The treatment of section 632.76 (2) (a), (ac), and (b) of the statutes first applies to individual disability insurance policies that are issued or renewed on the effective date of this subsection.

(3) DEPENDENT COVERAGE. The treatment of sections 40.51 (8) and (8m), 66.0137 (4), 111.91 (2) (t), 120.13 (2) (g), 185.981 (4t), 185.983 (1) (intro.), 609.74, 632.885, and 632.895 (15) (a) of the statutes first applies to all of the following:

(a) Except as provided in paragraphs (b) and (c), disability insurance policies that are issued or renewed, and governmental or school district self-insured health plans that are established, extended, modified, or renewed, on the effective date of this paragraph.

(b) Disability insurance policies covering employees who are affected by a collective bargaining agreement containing provisions inconsistent with this act that are issued or renewed on the earlier of the following:

1. The day on which the collective bargaining agreement expires.
2. The day on which the collective bargaining agreement is extended, modified, or renewed.

(c) Governmental or school district self-insured health plans covering employees who are affected by a collective bargaining agreement containing provisions inconsistent with this act that are established, extended, modified, or renewed on the earlier of the following:

1. The day on which the collective bargaining agreement expires.

Handwritten notes in the left margin: "NO #, (b), and (c) (intro.), 1, 2, 3, 4, 5, 6, and 7." with checkmarks next to each number.

Handwritten notes in the right margin: "111.91(2)(m), 609.74 (title)" with arrows pointing to the corresponding text in the statute.

2009-2010 DRAFTING INSERT
FROM THE
LEGISLATIVE REFERENCE BUREAU

LRB-1538/P2ins
PJK:.....

INSERT A-1

4 This bill changes the requirement under current law with respect to covering dependents. ~~RB~~

(END OF INSERT A-1)

(END OF INSERT A)

INSERT A-2

1004 does not have other health care coverage, and is not employed full time by an employer that offers health care coverage to its employees ~~RB~~

(END OF INSERT A-2)

INSERT 6-15

1 SECTION 1. 111.91 (2) (nm) of the statutes is amended to read:
2 111.91 (2) (nm) The requirements related to continuing offering and providing
3 coverage for a dependent student on a medical leave of absence under s. 632.895 (15).

History: 1971 c. 270; 1975 c. 39, 224; 1977 c. 196; 1979 c. 221; 1983 a. 27; 1985 a. 42; 1987 a. 27, 287, 331; 1989 a. 13, 31, 323; 1991 a. 269, 289; 1995 a. 27, 289; 1995 a. 302 s. 48; 1997 a. 27, 35, 155, 237; 1999 a. 9, 95, 115, 155; 2001 a. 16, 26; 2003 a. 33; 2007 a. 36.

(END OF INSERT 6-15)

INSERT 8-6

4 SECTION 2. 609.76 (title) of the statutes is amended to read:
5 609.76 (title) Coverage of student on medical leave dependents.

History: 2007 a. 36.

(END OF INSERT 8-6)

INSERT 18-15 1003

6 SECTION 3. 632.895 (15) (a) of the statutes is amended to read:
7 632.895 (15) (a) Subject to pars. (b) and par. (c), every insurer that issues a
8 disability insurance policy, and every self-insured health plan of the state or a



Sub 18-15 cont'd 2/13

1 county, city, town, village, or school district, ~~that provides coverage for a person as~~
2 ~~a dependent of the insured because the person is a full-time student shall continue~~
3 ~~to offer and, if so requested by an applicant or an insured, provide dependent~~
4 ~~coverage for the person if, due to a medically necessary leave of absence, he or she~~
5 ~~ceases to be a full-time student a child of the applicant or insured.~~ ✓

History: 1981 c. 39 ss. 4 to 12, 18, 20; 1981 c. 85, 99; 1981 c. 314 ss. 122, 123, 125; 1983 a. 36, 429; 1985 a. 29, 56, 311; 1987 a. 195, 327, 403; 1989 a. 129, 201, 229, 316, 332, 359; 1991 a. 32, 45, 123; 1993 a. 443, 450; 1995 a. 27 ss. 7048, 9126 (19); 1995 a. 201, 225; 1997 a. 27, 35, 75, 175, 237; 1999 a. 32, 115; 1999 a. 150 s. 672; 2001 a. 16, 82; 2007 a. 20 s. 9121 (6) (a); 2007 a. 36, 153.

6 SECTION 4. 632.895 (15) (b) of the statutes is repealed.

7 SECTION 5. 632.895 (15) (c) (intro.) of the statutes is amended to read:

8 632.895 (15) (c) (intro.) A policy or plan is not required to ~~continue provide the~~
9 ~~coverage under par. (a) only until if any of the following occurs applies:~~ ✓

History: 1981 c. 39 ss. 4 to 12, 18, 20; 1981 c. 85, 99; 1981 c. 314 ss. 122, 123, 125; 1983 a. 36, 429; 1985 a. 29, 56, 311; 1987 a. 195, 327, 403; 1989 a. 129, 201, 229, 316, 332, 359; 1991 a. 32, 45, 123; 1993 a. 443, 450; 1995 a. 27 ss. 7048, 9126 (19); 1995 a. 201, 225; 1997 a. 27, 35, 75, 175, 237; 1999 a. 32, 115; 1999 a. 150 s. 672; 2001 a. 16, 82; 2007 a. 20 s. 9121 (6) (a); 2007 a. 36, 153.

10 SECTION 6. 632.895 (15) (c) 1. of the statutes is repealed.

11 SECTION 7. 632.895 (15) (c) 2. of the statutes is amended to read:

12 632.895 (15) (c) 2. The person ~~becomes~~ child is employed full time and his or
13 her employer offers health care coverage to its employees. ✓

History: 1981 c. 39 ss. 4 to 12, 18, 20; 1981 c. 85, 99; 1981 c. 314 ss. 122, 123, 125; 1983 a. 36, 429; 1985 a. 29, 56, 311; 1987 a. 195, 327, 403; 1989 a. 129, 201, 229, 316, 332, 359; 1991 a. 32, 45, 123; 1993 a. 443, 450; 1995 a. 27 ss. 7048, 9126 (19); 1995 a. 201, 225; 1997 a. 27, 35, 75, 175, 237; 1999 a. 32, 115; 1999 a. 150 s. 672; 2001 a. 16, 82; 2007 a. 20 s. 9121 (6) (a); 2007 a. 36, 153.

14 SECTION 8. 632.895 (15) (c) 3. of the statutes is amended to read:

15 632.895 (15) (c) 3. The person ~~obtains~~ child has other health care coverage.

History: 1981 c. 39 ss. 4 to 12, 18, 20; 1981 c. 85, 99; 1981 c. 314 ss. 122, 123, 125; 1983 a. 36, 429; 1985 a. 29, 56, 311; 1987 a. 195, 327, 403; 1989 a. 129, 201, 229, 316, 332, 359; 1991 a. 32, 45, 123; 1993 a. 443, 450; 1995 a. 27 ss. 7048, 9126 (19); 1995 a. 201, 225; 1997 a. 27, 35, 75, 175, 237; 1999 a. 32, 115; 1999 a. 150 s. 672; 2001 a. 16, 82; 2007 a. 20 s. 9121 (6) (a); 2007 a. 36, 153.

16 SECTION 9. 632.895 (15) (c) 4. of the statutes is amended to read:

17 632.895 (15) (c) 4. The person ~~marries and is eligible for coverage under his or~~
18 ~~her spouse's health care coverage~~ child is married. ✓

History: 1981 c. 39 ss. 4 to 12, 18, 20; 1981 c. 85, 99; 1981 c. 314 ss. 122, 123, 125; 1983 a. 36, 429; 1985 a. 29, 56, 311; 1987 a. 195, 327, 403; 1989 a. 129, 201, 229, 316, 332, 359; 1991 a. 32, 45, 123; 1993 a. 443, 450; 1995 a. 27 ss. 7048, 9126 (19); 1995 a. 201, 225; 1997 a. 27, 35, 75, 175, 237; 1999 a. 32, 115; 1999 a. 150 s. 672; 2001 a. 16, 82; 2007 a. 20 s. 9121 (6) (a); 2007 a. 36, 153.

19 SECTION 10. 632.895 (15) (c) 5. of the statutes is amended to read:



Ins 18-15 cont'd 3 of 3

1 632.895 (15) (c) 5. The person reaches the child is 27 years of age at which
2 ~~coverage as a dependent who is a full-time student would otherwise end under the~~
3 ~~terms and conditions of the policy or plan or older.~~ ✓

History: 1981 c. 39 ss. 4 to 12, 18, 20; 1981 c. 85, 99; 1981 c. 314 ss. 122, 123, 125; 1983 a. 36, 429; 1985 a. 29, 56, 311; 1987 a. 195, 327, 403; 1989 a. 129, 201, 229, 316, 332, 359; 1991 a. 32, 45, 123; 1993 a. 443, 450; 1995 a. 27 ss. 7048, 9126 (19); 1995 a. 201, 225; 1997 a. 27, 35, 75, 175, 237; 1999 a. 32, 115; 1999 a. 150 s. 672; 2001 a. 16, 82; 2007 a. 20 s. 9121 (6) (a); 2007 a. 36, 153.

4 **SECTION 11.** 632.895 (15) (c) 6. of the statutes is amended to read:

5 632.895 (15) (c) 6. Coverage of the insured through whom the person child has
6 dependent coverage under the policy or plan is discontinued or not renewed.

History: 1981 c. 39 ss. 4 to 12, 18, 20; 1981 c. 85, 99; 1981 c. 314 ss. 122, 123, 125; 1983 a. 36, 429; 1985 a. 29, 56, 311; 1987 a. 195, 327, 403; 1989 a. 129, 201, 229, 316, 332, 359; 1991 a. 32, 45, 123; 1993 a. 443, 450; 1995 a. 27 ss. 7048, 9126 (19); 1995 a. 201, 225; 1997 a. 27, 35, 75, 175, 237; 1999 a. 32, 115; 1999 a. 150 s. 672; 2001 a. 16, 82; 2007 a. 20 s. 9121 (6) (a); 2007 a. 36, 153.

7 **SECTION 12.** 632.895 (15) (c) 7. of the statutes is repealed.

(END OF INSERT 18-15)

Kahler, Pam

From: Jablonsky, Sue - DOA [sue.jablonsky@wisconsin.gov]
Sent: Wednesday, January 28, 2009 4:35 PM
To: Kahler, Pam
Subject: FW: Draft review: LRB 09-1538/P2 Topic: Health insurance reform initiatives

From: Stegall, Jennifer L - OCI
Sent: Wednesday, January 28, 2009 4:22 PM
To: Nepple, Fred - OCI; Jablonsky, Sue - DOA
Cc: Walsh, Julie E - OCI; Mallow, Eileen K - OCI; Ruch, Guenther H - OCI
Subject: RE: Draft review: LRB 09-1538/P2 Topic: Health insurance reform initiatives

Sue,

I apologize for the delay, I was in a meeting that went long.

In addition to Fred's comments relating to dependent coverage, the draft indicates a child is not eligible for coverage if:

1. He or she is employed full time
2. Is offered coverage through his or her employer; or
3. Has health insurance coverage.

The intent was to only exclude those children from the mandate who are eligible for coverage from their employer for which the employee contribution is the same or less than the premium amount for coverage as a dependent under their parent's health plan.

Regarding IRO, we would like to remove the current \$25 fee, in an effort to make the process more consumer friendly.

Feel free to call with any follow up questions.

in A. 632. 835 (3) (a)

Thank you,

Jennifer Stegall
Policy Advisor
Office of the Commissioner of Insurance
608-267-7911

From: Nepple, Fred - OCI
Sent: Wednesday, January 28, 2009 3:45 PM
To: Jablonsky, Sue - DOA
Cc: Walsh, Julie E - OCI; Stegall, Jennifer L - OCI; Mallow, Eileen K - OCI; Ruch, Guenther H - OCI
Subject: RE: Draft review: LRB 09-1538/P2 Topic: Health insurance reform initiatives

01/28/2009

Sue

Jennifer Stegall may have some additional comments on the dependent provision. I have to catch a bus but can be reached at 608 347 1343 on by cell for anything urgent:

- 1) Page lines 12-14: change to parallel s. 632.746 (1) (a) : "condition, whether physical or mental, regardless of the cause of the condition, for which medical advice, diagnosis, care or treatment was recommended or received within 12 months before the effective date of coverage." I pointed Pam to the language included in the draft, taken from s. 632.76 (2) (b), Stats., which applies to Medicare supplement, but it is probably preferable to apply the language that currently is applicable to the group market. The Medicare supplement language is slightly more restrictive.
- 2) Page 9, line 6 add: "Nothing in this section affects an insured's right to commence a civil proceeding relating to a coverage denial determination." This to make it clear that if an insured requests, or fails to time request, a review the insured may nevertheless go to court.
- 3) Page 4, lines 24 and 25: the draft appears to require that the replacing product be "with more limited benefits or with a higher deductible." This contrary to the intent to allow replacing with a comparable product OR a more limited product. See the Georgia provision:

"An insurer operating in the major medical or comprehensive, guaranteed renewable business in the State of Georgia shall permit an insured to change his or her major medical or comprehensive coverage, upon election at any renewal, to a comparable product currently offered by that insurer or a product currently offered by that insurer with more limited product benefits; to a product with higher deductibles; or to modify his or her existing coverage to elect any optional higher deductibles under that policy. If such product, benefit, or deductible change is elected by the insured during the 60 day required period after notice of renewal premium increase but before renewal date, such insured shall not be subject to any new preexisting conditions exclusion that did not apply to his or her original coverage."

- 4) Page 13, dependent coverage: a) This is included by in effect repealing s. 632.895 (15) which provides for extended coverage for a student on medical leave of absence. This provision probably should be retained since it is possible that an insurer might provide dependent coverage for 27 or older. b) As drafted the provision requires an insurer to offer dependent coverage. We presume the intent is instead to require the extended coverage of a dependent IF the insurer provides dependent coverage. The language in s. 632.895 (15) works: "that provides coverage for a person as a dependent of the insured."

Fred Nepple, General Counsel

Fred.Nepple@oci.state.wi.us

Ph: (608)266-7726 FAX: (608)264-6228

Wisconsin Office of the Commissioner of Ins <http://oci.wi.gov>

PO Box 7873 Madison WI 53707-7873

125 S Webster St Madison WI 53702

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01/28/2009

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From: Jablonsky, Sue - DOA
Sent: Wednesday, January 28, 2009 8:33 AM
To: Nepple, Fred - OCI; Stegall, Jennifer L - OCI; Dilweg, Sean - OCI; Mallow, Eileen K - OCI
Subject: FW: Draft review: LRB 09-1538/P2 Topic: Health insurance reform initiatives

From: Barman, Mike [mailto:Mike.Barman@legis.wisconsin.gov]
Sent: Wednesday, January 28, 2009 7:52 AM
To: Jablonsky, Sue - DOA
Subject: Draft review: LRB 09-1538/P2 Topic: Health insurance reform initiatives

Draft Requester: Administration-Budget

Following is the PDF version of draft LRB 09-1538/P2.

Kahler, Pam

From: Jablonsky, Sue - DOA [sue.jablonsky@wisconsin.gov]
Sent: Wednesday, January 28, 2009 3:51 PM
To: Kahler, Pam
Subject: FW: Draft review: LRB 09-1538/P2 Topic: Health insurance reform initiatives

Changes from Fred

From: Nepple, Fred - OCI
Sent: Wednesday, January 28, 2009 3:45 PM
To: Jablonsky, Sue - DOA
Cc: Walsh, Julie E - OCI; Stegall, Jennifer L - OCI; Mallow, Eileen K - OCI; Ruch, Guenther H - OCI
Subject: RE: Draft review: LRB 09-1538/P2 Topic: Health insurance reform initiatives

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125 S Webster St Madison WI 53702

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From: Jablonsky, Sue - DOA

Sent: Wednesday, January 28, 2009 8:33 AM

To: Nepple, Fred - OCI; Stegall, Jennifer L - OCI; Dilweg, Sean - OCI; Mallow, Eileen K - OCI

Subject: FW: Draft review: LRB 09-1538/P2 Topic: Health insurance reform initiatives

From: Barman, Mike [mailto:Mike.Barman@legis.wisconsin.gov]

Sent: Wednesday, January 28, 2009 7:52 AM

To: Jablonsky, Sue - DOA

Subject: Draft review: LRB 09-1538/P2 Topic: Health insurance reform initiatives

Draft Requester: Administration-Budget

Following is the PDF version of draft LRB 09-1538/P2.

Kahler, Pam

From: Gauger, Michelle C - DOA [Michelle.Gauger@Wisconsin.gov]
Sent: Thursday, January 29, 2009 12:37 PM
To: Stegall, Jennifer L - OCI
Cc: Jablonsky, Sue - DOA; Nepple, Fred - OCI; Kahler, Pam
Subject: RE: Draft review: LRB 09-1538/P2 Topic: Health insurance reform initiatives
Attachments: image001.gif; image002.gif; image003.gif

Hello Jennifer,

Regarding this change, in the briefing with the Governor, the Governor explicitly requested that the current student provision be amended to increase the age to 26 and no longer require that they be a student nor should they be required to be a dependent. The other provisions should remain the same. The mandate language requested by OCI was not approved.

With that in mind, are there changes to the draft that need to be made to be technically correct or because it is not in compliance with the decision made by the Governor?

Thanks!

Michelle Gauger

From: Stegall, Jennifer L - OCI
Sent: Wednesday, January 28, 2009 4:22 PM
To: Nepple, Fred - OCI; Jablonsky, Sue - DOA
Cc: Walsh, Julie E - OCI; Mallow, Eileen K - OCI; Ruch, Guenther H - OCI
Subject: RE: Draft review: LRB 09-1538/P2 Topic: Health insurance reform initiatives

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01/29/2009

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 Office of the Commissioner of Insurance
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125 S Webster St Madison WI 53702

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From: Jablonsky, Sue - DOA

Sent: Wednesday, January 28, 2009 8:33 AM

To: Nepple, Fred - OCI; Stegall, Jennifer L - OCI; Dilweg, Sean - OCI; Mallow, Eileen K - OCI

Subject: FW: Draft review: LRB 09-1538/P2 Topic: Health insurance reform initiatives

From: Barman, Mike [<mailto:Mike.Barman@legis.wisconsin.gov>]

Sent: Wednesday, January 28, 2009 7:52 AM

To: Jablonsky, Sue - DOA

Subject: Draft review: LRB 09-1538/P2 Topic: Health insurance reform initiatives

Draft Requester: Administration-Budget

Following is the PDF version of draft LRB 09-1538/P2.

Kahler, Pam

From: Gauger, Michelle C - DOA [Michelle.Gauger@Wisconsin.gov]
Sent: Thursday, January 29, 2009 12:43 PM
To: Kahler, Pam
Cc: Jablonsky, Sue - DOA
Subject: RE: Draft review: LRB 09-1538/P2 Topic: Health insurance reform initiatives
Attachments: image001.gif, image002.gif, image003.gif

Pam,

After talking these through with Jennifer at OCI, these four changes from Fred can be included in the draft.

Please let me know if you have any questions.

From: Kahler, Pam [mailto:Pam.Kahler@legis.wisconsin.gov]
Sent: Thursday, January 29, 2009 12:28 PM
To: Gauger, Michelle C - DOA
Subject: FW: Draft review: LRB 09-1538/P2 Topic: Health insurance reform initiatives

First from Fred.

From: Jablonsky, Sue - DOA [mailto:sue.jablonsky@wisconsin.gov]
Sent: Wednesday, January 28, 2009 3:51 PM
To: Kahler, Pam
Subject: FW: Draft review: LRB 09-1538/P2 Topic: Health insurance reform initiatives

Changes from Fred

From: Nepple, Fred - OCI
Sent: Wednesday, January 28, 2009 3:45 PM
To: Jablonsky, Sue - DOA
Cc: Walsh, Julie E - OCI; Stegall, Jennifer L - OCI; Mallow, Eileen K - OCI; Ruch, Guenther H - OCI
Subject: RE: Draft review: LRB 09-1538/P2 Topic: Health insurance reform initiatives

Sue

Jennifer Stegall may have some additional comments on the dependent provision. I have to catch a bus but can be reached at 608 347 1343 on by cell for anything urgent:

- 1) Page lines 12-14: change to parallel s. 632.746 (1) (a) :”condition, whether physical or mental, regardless of the cause of the condition, for which medical advice, diagnosis, care or treatment was recommended or received within 12 months before the effective date of coverage.” I pointed Pam to the language included in the draft, taken from s. 632.76 (2) (b), Stats., which applies to Medicare supplement, but it is probably preferable to apply the language that currently is applicable to the group market. The Medicare supplement language is slightly more restrictive.
- 2) Page 9, line 6 add: “Nothing in this section affects an insured’s right to commence a civil proceeding relating to a coverage denial determination.” This to make it clear that

if an insured requests, or fails to time request, a review the insured may nevertheless go to court.

- 3) Page 4, lines 24 and 25: the draft appears to require that the replacing product be "with more limited benefits or with a higher deductible." This contrary to the intent to allow replacing with a comparable product OR a more limited product. See the Georgia provision:

"An insurer operating in the major medical or comprehensive, guaranteed renewable business in the State of Georgia shall permit an insured to change his or her major medical or comprehensive coverage, upon election at any renewal, to a comparable product currently offered by that insurer or a product currently offered by that insurer with more limited product benefits; to a product with higher deductibles; or to modify his or her existing coverage to elect any optional higher deductibles under that policy. If such product, benefit, or deductible change is elected by the insured during the 60 day required period after notice of renewal premium increase but before renewal date, such insured shall not be subject to any new preexisting conditions exclusion that did not apply to his or her original coverage."

- 4) Page 13, dependent coverage: a) This is included by in effect repealing s. 632.895 (15) which provides for extended coverage for a student on medical leave of absence. This provision probably should be retained since it is possible that an insurer might provide dependent coverage for 27 or older. b) As drafted the provision requires an insurer to offer dependent coverage. We presume the intent is instead to require the extended coverage of a dependent IF the insurer provides dependent coverage. The language in s. 632.895 (15) works: "that provides coverage for a person as a dependent of the insured."

Fred Nepple, General Counsel

Fred.Nepple@oci.state.wi.us

Ph: (608)266-7726 FAX: (608)264-6228

Wisconsin Office of the Commissioner of Ins <http://oci.wi.gov>

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From: Jablonsky, Sue - DOA

Sent: Wednesday, January 28, 2009 8:33 AM

To: Nepple, Fred - OCI; Stegall, Jennifer L - OCI; Dilweg, Sean - OCI; Mallow, Eileen K - OCI

Subject: FW: Draft review: LRB 09-1538/P2 Topic: Health insurance reform initiatives

From: Barman, Mike [mailto:Mike.Barman@legis.wisconsin.gov]

Sent: Wednesday, January 28, 2009 7:52 AM

To: Jablonsky, Sue - DOA

Subject: Draft review: LRB 09-1538/P2 Topic: Health insurance reform initiatives

Draft Requester: Administration-Budget

Following is the PDF version of draft LRB 09-1538/P2.

Kahler, Pam

From: Gauger, Michelle C - DOA [Michelle.Gauger@Wisconsin.gov]
Sent: Thursday, January 29, 2009 12:46 PM
To: Kahler, Pam
Cc: Jablonsky, Sue - DOA
Subject: RE: Draft review: LRB 09-1538/P2 Topic: Health insurance reform initiatives
Attachments: image001.gif; image002.gif; image003.gif; image004.gif; image005.gif; image006.gif

Pam,

Jennifer Stegall and I have agreed that these two changes can be made to the dependent coverage mandate:

1. Should not preclude an insurer from offering coverage beyond the age of 26, particularly for students who may be older (Fred's item 4-also in my other email)
2. The Governor requested that the mandate did not require the child to be a dependant in order to qualify for the coverage.

You can ignore the other changes from OCI related to the parental coverage mandate. Please let me know if you have questions and thank you!

Michelle

From: Gauger, Michelle C - DOA
Sent: Thursday, January 29, 2009 12:37 PM
To: Stegall, Jennifer L - OCI
Cc: Jablonsky, Sue - DOA; Nepple, Fred - OCI; Kahler, Pam - LEGIS
Subject: RE: Draft review: LRB 09-1538/P2 Topic: Health insurance reform initiatives

Hello Jennifer,

Regarding this change, in the briefing with the Governor, the Governor explicitly requested that the current student provision be amended to increase the age to 26 and no longer require that they be a student nor should they be required to be a dependent. The other provisions should remain the same. The mandate language requested by OCI was not approved.

With that in mind, are there changes to the draft that need to be made to be technically correct or because it is not in compliance with the decision made by the Governor?

Thanks!

Michelle Gauger

From: Stegall, Jennifer L - OCI
Sent: Wednesday, January 28, 2009 4:22 PM
To: Nepple, Fred - OCI; Jablonsky, Sue - DOA
Cc: Walsh, Julie E - OCI; Mallow, Eileen K - OCI; Ruch, Guenther H - OCI
Subject: RE: Draft review: LRB 09-1538/P2 Topic: Health insurance reform initiatives

Sue,

I apologize for the delay, I was in a meeting that went long.

01/29/2009

In addition to Fred's comments relating to dependent coverage, the draft indicates a child is not eligible for coverage if:

1. He or she is employed full time
2. Is offered coverage through his or her employer; or
3. Has health insurance coverage.

The intent was to only exclude those children from the mandate who are eligible for coverage from their employer for which the employee contribution is the same or less than the premium amount for coverage as a dependent under their parent's health plan.

Regarding IRO, we would like to remove the current \$25 fee, in an effort to make the process more consumer friendly.

Feel free to call with any follow up questions.

Thank you,

Jennifer Stegall
Policy Advisor
Office of the Commissioner of Insurance
608-267-7911

From: Nepple, Fred - OCI
Sent: Wednesday, January 28, 2009 3:45 PM
To: Jablonsky, Sue - DOA
Cc: Walsh, Julie E - OCI; Stegall, Jennifer L - OCI; Mallow, Eileen K - OCI; Ruch, Guenther H - OCI
Subject: RE: Draft review: LRB 09-1538/P2 Topic: Health insurance reform initiatives

Sue

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Fred Nepple, General Counsel

Fred.Nepple@oci.state.wi.us

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From: Jablonsky, Sue - DOA

Sent: Wednesday, January 28, 2009 8:33 AM

To: Nepple, Fred - OCI; Stegall, Jennifer L - OCI; Dilweg, Sean - OCI; Mallow, Eileen K - OCI

Subject: FW: Draft review: LRB 09-1538/P2 Topic: Health insurance reform initiatives

From: Barman, Mike [<mailto:Mike.Barman@legis.wisconsin.gov>]

Sent: Wednesday, January 28, 2009 7:52 AM

To: Jablonsky, Sue - DOA

Subject: Draft review: LRB 09-1538/P2 Topic: Health insurance reform initiatives

Draft Requester: Administration-Budget

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01/29/2009